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BSN 266 HESI Med Surg Exam (New 2023/ 2024 Update) Questions and Verified Answers|100% Correct| Graded A- Nightingale

QUESTION

The nurse is preparing a client for orthopedic surgery on the left leg and completing a safety checklist before transport to the operating room. Which items should the nurse remove from the client? (Select all that apply.)
Select all that apply
A. Nail polish. B. Hearing aid.
C. Wedding band. D. Left leg brace. E. Contact lenses.
F. Partial dentures.

Answer:
AB,E,F Rationale
The removal of nail polish provides a more accurate pulse oximetry readings and evaluation of capillary refill. Hearing aids, contact lenses, and partial dentures are removed to prevent damage, loss or misplacement, or injury during surgery. Ideally, give the client's significant other the contact lenses if they are not the disposable ones, hearing aids and partial dentures once placed in an appropriate labeled container to hold for safe keeping. If no significant other is not able to hold onto the items, then secured them in an appropriate and safe place

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QUESTION

What instruction should the nurse include in the discharge teaching for a client who needs to perform self-catheterization technique at home?

A. Catheterize every 3 to 4 hours. B. Maintain sterile technique.
C. Use the Cred maneuver before catheterization.
D. Drink 500 ml of fluid within 2 hours of catheterization.

Answer:
A Rationale
The average interval between catheterizations for adults is every 3 to 4 hours. Although sterile technique is indicated in healthcare facilities, clean technique is often followed by the client when performing self-catheterization at home

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QUESTION

The nurse assesses a long-term resident of a nursing home and finds the client has a fungal infection (candidiasis) beneath both breasts. To prevent nosocomial infection, which protocol should the nurse review with the rest of the staff?
A. Follow contact isolation procedures. B. Wash hands after caring for the client.
C. Wear gloves when providing personal care.
D. Restrict pregnant staff or visitors into the room.

Answer:
B Rationale
The organism Candida albicans, which causes this infection, is part of the normal flora on the skin of most adults. Good handwashing is all that is needed to prevent nosocomial spread.

QUESTION

What assessment finding should the nurse identify that indicates a client with an acute asthma exacerbation is beginning to improve after treatment? A. Wheezing becomes louder.
B. Cough remains unproductive.
C. Vesicular breath sounds decrease.
D. Bronchodilators stimulate coughing.

Answer:
A Rationale
In an acute asthma attack, air flow may be so significantly restricted that breath sounds and wheezing is diminished. If the client is successfully responding to bronchodilators and respiratory treatments, wheezing should become louder as the air flow increases in the airways. As the airways open and mucous is mobilized in response to treatment, the cough should become more productive

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QUESTION

When caring for a client with a percutaneous endoscopic gastrostomy (PEG) tube, what protocols should the nurse implement for intermittent feed- ings? (Select all that apply.)
Select all that apply
A. Assessing residual amounts once a day.
B. Keeping the head of the bed elevated 30 degrees. C. Changing the enteral-feeding bag every 24 hours.

D. Checking the placement of the tube by means of gastric aspiration.
E. Flushing the tube with 50 ml of normal saline solution after each feeding.

Answer:
B, C, D, E
Rationale

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Keeping the head of the bed elevated 30 degrees, changing the enteral-feeding bag every 24 hours, checking the placement of the tube by means of gastric aspiration, and flushing the tube with 50 ml of normal saline solution after each feeding are interventions used to provide care of the client with a PEG tube. Residual amounts should be assessed each time, prior to each feeding

QUESTION

The home health nurse is assessing a client with terminal lung cancer who is receiving hospice care. Which activity should be assigned to the hospice practical nurse (PN)?
A. Administer medications for pain relief, shortness of breath, and nausea.
B. Clarify family members' feelings about the meaning of client behaviors and symptoms.
C. Develop a plan of care after assessing the needs of the client and family. Teach the family to recognize restlessness and grimacing as signs of client discomfort.

Answer:
A
Rationale
Hospice care provides symptom management and pain control during the dying process and enhances the quality of life for a client who is terminally ill. Administering medication and monitoring for therapeutic and adverse effects is within the scope of practice for the PN.

QUESTION

A man who smokes two packs of cigarettes a day wants to know if smoking is contributing to the difficulty that he and his wife are having getting pregnant. What information is best for the nurse to provide? (Select all that apply.) Select all that apply
A. Only marijuana cigarettes affect sperm count.
B. Smoking can decrease the quantity and quality of sperm.
C. The first semen analysis should be repeated to confirm sperm counts. D. Cessation of smoking improves general health and fertility.
E. Sperm specimens should be collected in 2 subsequent days.

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Answer:
B, D Rationale
The use of tobacco, alcohol, and marijuana may affect a man's sperm counts.

QUESTION

When teaching a client with breast cancer about the prescribed radiation therapy for treatment, what information is important to include?
Dry, itchy skin changes may occur. There is a possibility of long bone pain.
Permanent pigment changes to the breast may result.

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A low-residue diet may be ordered to reduce the likelihood of diarrhea

Answer:
A Rationale
Side effects from radiation to the breast most often include temporary skin changes, such as: dryness, tenderness, redness, swelling, and pruritis.

QUESTION

The nurse is caring for a client with human immunodeficiency virus (HIV) infection who develops Mycobacterium avium complex (MAC). What is the most significant desired outcome for this client?
A. Free from injury of drug side effects. B. Return to pre-illness weight.
C. Adequate oxygenation.
D. Maintenance of intact perineal skin.

Answer:
B Rationale
MAC is an opportunistic infection that presents as a tuberculosis-like pulmonary process. MAC is a major contributing factor to the development of wasting syndrome, so the most significant desired outcome is the client's return to a pre-illness weight using oral, enteral, or parenteral supplementation as needed.

QUESTION

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The nurse is caring for a client with multiple trauma after a motor vehicle collision. The nurse learns that the client has secondary syphilis. What pre- caution should the nurse implement?
A. A mask should be worn by anyone entering the client's room.
B. Handwashing is required before and after contact with the client. C. Gloves should be worn during direct contact with the client's skin. No precautions in addition to standard precautions are necessary

Answer:
C Rationale
The secondary stage of syphilis is a systemic blood-borne disease that presents with skin lesions and rashes that may drain the highly contagious spirochete, so gloves should be worn during direct contact with the client's skin. The client should be placed on "contact precautions".

QUESTION

The nurse is preparing a teaching plan for a client with newly diagnosed glacoma and a history of allergic rhinitis. Which information is most important for the nurse to provide the client about using over-the-counter (OTC) medica- tions for allergies?

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